Bandolier 42

What do we think?
What do we know?
What can we prove?

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Reassurance

All of us need reassurance from time to time - that we are doing a good job, that our decisions are mostly correct, or, if we are patients with symptoms, that there may be nothing to worry about. One example of effective reassurance is highlighted this month on page 5. GPs being positive with patients yielded good results in a randomised trial.

The issue of how we can provide effective reassurance is of immense clinical importance. There is a need to deal with 'emotional' reassurance as well as information reassurance. This is where ***Bandolier*** would like to see some information or action on what constitutes effective reassurance and on how we should deliver it.

Why make such a fuss? Because our failure to deliver this effective reassurance has huge clinical consequences, and, wait for it, what about the consequences for the NHS? We know that patients with particular concentrations of symptoms can bounce round and round the system without any joy for them or their carers. ME, chronic fatigue or the more generic Medically Unexplained Physical Symptoms spring to mind, but there are many others. Effective reassurance is important for those people and for those who look after them. What about it? Would you come to a ***Bandolier*** Conference on this topic?

Reassuring evidence

We also need to have some idea that we are using the best evidence from reviews or systematic reviews. ***Bandolier*** points out (yet again) that the highest quality of evidence tends to be less positive. This month, on page 3, we give a simple guide to judging quality of reviews so that you can reassure yourself when reading reviews.

Unanswered questions

Bandolier's reassurance comes from those of you who write and give us your views, or ask questions, or tell us what you want. Sometimes we can help. Often we can't. As an experiment this month we carry a table of some unanswered questions to see if ***Bandolier*** readers can help. If it works, we might try and do more in this area.

Bandolier conferences

Bandolier is working hard to get more conferences on the road. We don't quite have a date for the late October one-day conference on Chlamydia infection, but the venue is likely to be London, and details are being finalised even as ***Bandolier*** is put to bed. For early notification fax Eileen on 01865 226978.

MINDSTRETCHER

What do you do when there is no evidence? Carry on with what you are doing because you have no evidence to stop, or stop what you are doing because there is no evidence to carry on? This is not a hypothetical question, because in this new 'evidence-based world', much of what we do is still often based on what is time-honoured rather than trial-honoured.

The obvious thing to do, and one that ***Bandolier*** tries to encourage, is to search out a systematic review, and preferably one based on randomised trials. This should give the highest level of evidence. But what if reviews themselves differ in the advice they give?

Prophylactic removal of impacted third molars

Opinions about rophylactic removal of impacted third molars vary widely. Some people seem to think it is a good thing, because it prevents later pain and suffering. Others can't see the reason for doing an unnecessary procedure unless the teeth are causing problems.

A systematic review of reviews [1] examined the pathologies associated with impacted third molars, and outcomes following surgical removal of third molars. A thorough literature search found 12 published reviews fit for inclusion, and five which were not.

For inclusion a review had to :

1. be a review of research literature
2. address either pathology and/or symptoms associated with impacted third molars or outcomes following surgical removal
3. be published after 1985 and be written in English.

In this issue

*The views expressed in **Bandolier** are those of the authors, and are not necessarily those of the NHSE Anglia & Oxford*

Results of reviewing the reviews

Only one review gave its search strategy and criteria for including a research paper. The number of references ranged from 9 to 149 (median 43 references) - with wide variations also in the number of references addressing different aspects of the problem.

And what was their conclusion?

Two reviews concluded that prophylactic removal of third molars is a good thing. The other ten concluded that there was a lack of evidence to support prophylactic removal of impacted third molars.

And the review of reviews itself concluded that in the absence of good evidence to support prophylactic removal there appears to be little justification for removing pathology-free impacted third molars.

What to do when systematic reviews disagree

Fortunately we can now find a guide through this particular minefield [2]. Ask some simple questions:

- Do the reviews ask the same question?
- Do the reviews include the same trials?
- Is the same endpoint used, and are the methods of analysis comparable?

None of this is difficult stuff, but the authors of this useful contribution take us step by step through the important signposts to resolving discrepancies. Of course, there may always be times when reviewers disagree, but then that's all part of the fun. If nobody disagreed we wouldn't make much progress.

Never mind the quality?

No, with systematic reviews you must take quality into account. That the outcome of a systematic review is likely to be influenced by its methodological quality has been thoroughly examined in systematic reviews in pain [3].

This paper looked for pain meta-analyses. To be included in this study, reports had to meet the following criteria:

1. They had to be described as meta-analyses or, if not, they had to include pooled analysis of the results of several independent primary studies. Studies in which statistical synthesis had been planned but was deemed to be inappropriate were also included.
2. They had to incorporate trials in which pain was an outcome measure or in which analgesic interventions were compared for outcomes other than pain within the context of a painful condition (e. g. a study looking at the validity of grip strength to assess the effectiveness of NSAIDs in rheumatoid arthritis).
3. They had to be published or accepted for publication.

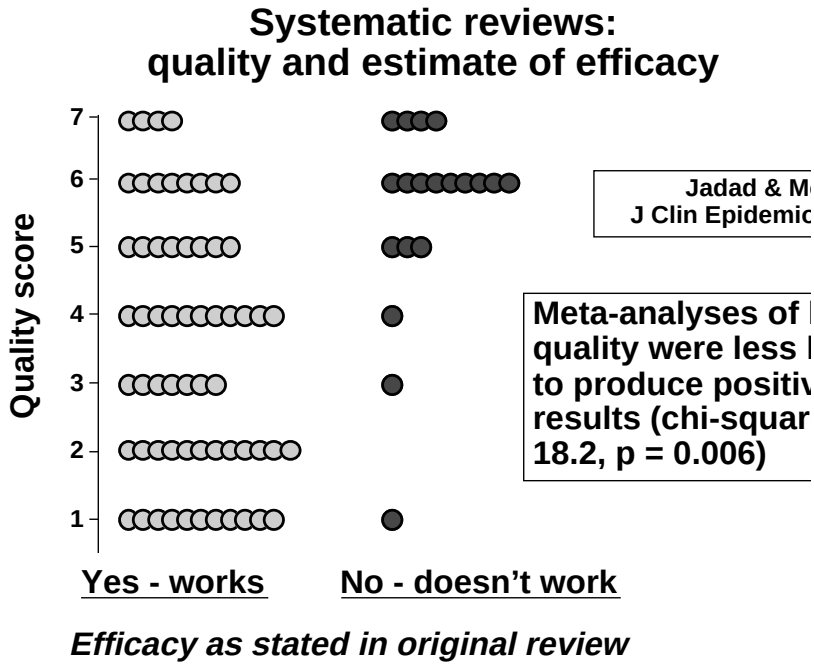
Each study was evaluated independently (and blinded) by both the investigators using Oxman and Guyatt's index [4]. The details of this are given on the next page, together with information about its use, so ***Bandolier*** readers can use it themselves. Only items scored as 'yes' or 'not applicable' were regarded as present and those scored as 'no', 'cannot tell' or 'partially' were regarded as absent. The maximum possible overall score for a given study was 7.

Did quality make a difference?

Of the reports found, the conclusions were positive in 60 meta-analyses (75%), negative in 7 (9%) and uncertain in 12 (15%). One meta-analysis (1%) did not reach any conclusion.

The distribution of the overall scores between meta-analyses with positive conclusions and those with negative or uncertain results was different (chi-squared 18.2, p = 0.006). Meta-analyses of high quality were less likely to produce positive results. Sixteen out of 19 meta-analyses with negative or uncertain results had overall quality scores above the median value, while that was the case for only 20 of the 60 with positive results.

Meta-analyses which included only randomised trials were less likely to produce positive conclusions (19 of 31, 61%) than those which included other study designs as well as or instead of RCTs (41 of 49, 84%). The difference was statistically significant (chi-square = 5.07; p = 0.024).



Reviewing a review: DIY tests of quality [4]

The purpose is to evaluate the scientific quality (i.e., adherence to scientific principles) of research overviews (review articles) published in the medical literature. It is not intended to measure literary quality, importance, relevance, originality, or other attributes of overviews.

The index is for assessing overviews of primary ("original") research on pragmatic questions regarding causation, diagnosis, prognosis, therapy, or prevention. A research overview is a survey of research. The same principles that apply to epidemiological surveys apply to overviews; a question must be clearly specified, a target population identified and accessed, appropriate information obtained from that population in an unbiased fashion, and conclusions derived, sometimes with the help of formal statistical analysis, as is done in "meta-analyses". The fundamental difference between overviews and epidemiological surveys is the unit of analysis, not scientific issues that the questions in this index address.

Since most published overviews do not include a methods section it is difficult to answer some of the questions in the index. Base your answers, as much as possible, on information provided in the overview. If the methods that were used are reported incompletely relative to a specific item, score that item as "partially". Similarly, if there is no information provided regarding what was done relative to a particular question, score it as "can't tell", unless there is information in the overview to suggest either that the criterion was or was not met.

For Question 8, if no attempt has been made to combine findings, and no statement is made regarding the inappropriateness of combining findings, check "no". If a summary (general) estimate is given anywhere in the abstract, the discussion, or the summary section of the paper, and it is not reported how that estimate was derived, mark "no" even if there is a statement regarding the limitations of combining the findings of the studies reviewed. If in doubt mark "can't tell".

For an overview to be scored as "yes" on Question 9, data (not just citations) must be reported that support the main conclusions regarding the primary question(s) that the overview addresses.

The score for Question 10, the overall scientific quality, should be based on your answers to the first nine questions. The following guidelines can be used to assist with deriving a summary score: If the "can't tell" option is used one or more times on the preceding questions, a review is likely to have minor flaws at best and it is difficult to rule our major flaws (i.e., a score of 4 or lower). If the "no" option is used on Questions 2, 4, 6 or 8, the review is likely to have major flaws (i.e., a score of 3 or less, depending on the number and degree of the flaws).

Quality features

1	Were the search methods used to find evidence on the primary question(s) stated?	No	Partially	Yes
2	Was the search for evidence reasonably comprehensive?	No	Can't tell	Yes
3	Were the criteria used for deciding which studies to include in the overview reported?	No	Partially	Yes
4	Was bias in the selection of studies avoided?	No	Can't tell	Yes
5	Were the criteria used for assessing the validity of the included studies reported?	No	Partially	Yes
6	Was the validity of all the studies referred to in the text assessed using appropriate criteria ?	No	Can't tell	Yes
7	Were the methods used to combine the findings of the relevant studies (to reach a conclusion) reported?	No	Partially	Yes
8	Were the findings of the relevant studies combined appropriately relative to the primary question of the overview ?	No	Can't tell	Yes
9	Were the conclusions made by the author(s) supported by the data and/or analysis reported in the overview?	No	Partially	Yes

10 How would you rate the scientific quality of this overview?

Flaws						
Extensive		**Major**		**Minor**		**Minimal**
1	2	3	4	5	6	7

Comment

Reviews which are of high quality tended to be less enthusiastic about an intervention. Those which used only randomised trials were also less enthusiastic. This serves to drive home the lesson about using high quality evidence in making choices.

So if we are faced with reviews, systematic or not, which disagree, go for the highest quality. And if reviews are not systematic, or contain no randomised trials, like those for the prophylactic removal of wisdom teeth, regard them with a cold and fishy eye!

References:
1 F Song, DP Landes, A-M Glenny, TA Sheldon. Prophylactic removal of impacted third molars: an assessment of published reviews. Oral Surgery 1997 182: 339-46.
2 AR Jadad, DJ Cook, GP Browman. A guide to interpreting discordant systematic reviews. Canadian Medical Association Journal 1997 156: 1411-6.
3 AR Jadad, HJ McQuay. Meta-analyses to evaluate analgesic interventions: a systematic qualitative review of their methodology. Journal of Clinical Epidemiology 1996 49: 235-43.
4 Oxman AD, Guyatt GH. Validation of an index of the quality of review articles. Journal of Clinical Epidemiology 1991 44: 1271-8.

GENEWATCH: SCREENING FOR FRAGILE-X SYNDROME

Health Technology Assessment is an important part of the NHS R&D programme. It aims to ensure that high quality information on the costs, effectiveness and broad impact of health technologies is collected and disseminated to those who work in, and manage the NHS. Research is targeted to those areas where new evidence should lead to the greatest benefits to patients and the most efficient use of NHS resources.

HTA report

A recently published report commissioned by the HTA programme sets out the current state of knowledge about screening for the fragile-X syndrome. The work reported involved a comprehensive systematic review of over 500 papers on the subject. Its stated purpose was to provide the information needed to decide whether to use DNA testing to screen for the disorder. In this it is, not surprisingly, only partly successful. Most of its recommendations are for further studies because current information isn't adequate to allow rational decisions to be made about future screening strategies.

Fragile-X

Fragile-X syndrome is the second most common cause of severe mental retardation after Down's syndrome. The latest population prevalence figures are about 1 in 4,000 for males and 1 in 8,000 for females. About 6% of institutionalised individuals with learning difficulties have the syndrome. It was first described in 1969 and the responsible gene, FMR-1, was identified in 1991. In addition to varying degrees of mental retardation the clinical phenotype often includes macro-orchidism in males, abnormal facies with prominent forehead, large jaw and large ears, joint laxity and behavioural problems. The syndrome gets its name from the fact that chromosomal analysis usually reveals a narrowing near the end of the long arm of the X chromosome (Xq27).

Fragile-X is one of a small group of genetic disorders where the abnormality is an unstable non-Mendelian mutation with an increased number of copies of a specific repeated trinucleotide sequence. It displays unusual inheritance patterns for an X-linked disease in that males can be phenotypically normal carriers of the pre-mutation (as shown in the Table, with a comparison with Huntingdon's disease and myotonic dystrophy), and their children are not at an increased risk of the disorder. In contrast the children of female carriers are at an increased risk, since the pre-mutation is less stable and more likely to increase in repeat size in females. Females may be affected, but are usually less severely mentally retarded than affected males.

The recommendations made in the report are:-

1. Cascade screening (ie in affected families) should be regarded as of proven benefit, but national audit of current practice is needed
2. Paediatric screening - studies are needed to assess current practice
3. Antenatal screening - the practicality, acceptability and cost of routine antenatal screening should be assessed
4. The psychosocial consequences of being identified as a 'carrier' should be studied
5. A central register for all diagnoses should be established.

Dilemma

These recommendations reflect the dilemmas faced by almost all new genetic screening programmes. While we now have

Characteristics of commonest Trinucleotide Repeat Syndromes

	Fragile-X syndrome	Huntington's disease	Myotonic dystrophy
approximate prevalence	1 in 4,000	1 in 20,000	1 in 25,000
age of onset	congenital	30 to 55	congenital or mid-life
nucleotide sequence	CCG	CAG	CTG
no. copies 'normal'	6 to 50	9 to 34	5 to 30
no. copies 'pre-mutation' /carrier	50 to 200		50 to 80
no. copies full mutation /cases	200 - 000's	37 to 80	up to 2000
gene name	FMR -1	HD	MD
chromosome site	Xq27.3	4p16.3	19q13.2
OMIM gene number	309550	143100	160900

the technology to undertake sophisticated DNA screening and we know that the incidence of new cases can be reduced, we have little sound information on the human costs of population screening programmes or the real cost/benefits to the NHS. It is critically important that these questions are addressed.

The costs to prevent one affected birth through pre-natal diagnosis in two cascade screening programmes have been reported as $14,200 (Australia, 1986 prices) and $12,740 (US, 1992 prices). It has also been estimated that the lifetime costs of care for an affected individual are in the region of $1-2 million.

Reference:
1 Murray J, Cuckle H, Taylor G, Hewison J. Screening for Fragile X syndrome. Health Technology Assessment 1997; 1(4).
http://www.soton.ac.uk/~wi/hta/index.html

OLD CURIOSITY SHOP

Bandolier tries to face the world with a cheerful face, but like all of us can be cast down by incidents as disparate as the weather, bureaucracy or a particularly dense referee. *Nil illigitimi carborundum* might be a useful motto, though, since being positive has a payback. There is evidence that the doctor herself is a powerful therapeutic agent, and that patients can benefit from a positive approach from their GP.

The importance of being positive

A randomised trial of a positive attitude in GP consultations was made by a single GP in consultations where no firm diagnosis could be made. All such symptomatic patients could have one of four consultations:

1. A positive consultation in which the patient was given a firm diagnosis, given a prescription, and told that it would certainly make them better.
2. A positive consultation in which the patient was given a firm diagnosis and told that they required no prescription to get better.
3. A negative consultation in which they were told (honestly) "I cannot be certain what is the matter with you", given a prescription and told "I am not sure that the treatment I am about to give you will have an effect".
4. A negative consultation in which they were told "I cannot be certain what is the matter with you", followed by "and therefore I will give you no treatment".

Negative consultations were closed by the GP telling patients to come back after a few days if they felt no better. Wherever a prescription was given, it was 3 mg thiamine hydrochloride.

Two weeks after the consultation each patient was sent a card asking:

1. Did you get better?
2. How many days after seeing the doctor did you get better?
3. Did you need any further treatment?

Results

The patients in whom no firm diagnosis could be made had a variety of complaints. The commonest complaint in the 200 patients was cough, sore throat, nasal congestion, or cold (in 81 patients), pain in abdomen, back, leg, head, chest, ear, muscles, arm, breast and neck (in 69), giddiness (9) and tiredness (8).

A positive consultation produced a higher proportion of patients (64%) getting better than a negative consultation (39%). There was no effect of giving a prescription. Overall the number needed to treat (NNT) for a positive consultation was 4.0 (2.6 to 8.6) for the patient to get better within two weeks.

Comment

The only treatment used in this study was that of a positive consultation in patients who were symptomatic but in whom no firm diagnosis could be made. The report made a number of attempts to analyse other information collected, but no other factors were important.

The NNT of four means that of four patients visiting their GP with symptoms but in whom no firm diagnosis can be made, and given a positive consultation, one will get better within two weeks who would not have if they had received a negative consultation. But that underestimates the power of the positive consultation, because other factors also play their part, including self-limiting disorders. Sixty four percent of such patients got better with a positive consultation.

Reference:
1 KB Thomas. General practice consultations: is there any point in being positive? British Medical Journal 1987 294: 1200-2.

Effect of a positive consultation by general practitioner

	Positive consultation (better/total)	Negative consultation (better/total)	Relative benefit (95%CI)	NNT (95%CI)
Prescription given	32/50	21/50		4.6 (2.4 - 34)
No prescrition given	32/50	18/50		3.6 (2.1 - 10)
Total	64/100	39/100	1.6 (1.2 - 2.2)	4.0 (2.6 - 8.6)

VALUE-BASED DECISION-MAKING

However obsessed we may become about evidence-based decision-making, decisions are never (or rarely) based solely on evidence alone. Two other factors have to be taken into account - resources (pretty obvious, this), and values (how individuals and society makes judgements about what they want). When different groups have different judgements about evidence, and perhaps different judgements about values, then life can become very difficult.

Breast cancer screening in the USA

The way in which values can influence decisions, even when the evidence is of very high quality, is illustrated by the recent twisting and turning in the USA about breast cancer screening in women under 40 years. An NIH Consensus Conference concluded that routine mammography was not indicated universally for women in their forties [1]. Sections of the medical, political and media world went ballistic, with accusations of fraud, of condemning women to death, and the New York Times and Congress made up their own minds and called for screening to be introduced [2].

The National Cancer Institute's Advisory Board reviewed the decision, and on a 17-1 vote recommended mammographic screening every one to two years for women aged 40 to 49 years who are at average risk.

UK/US - snails and evangelists

The evidence is the same, but the interpretation differs. The US panel has made a decision that no UK panel would be likely to make. In the US they might argue that such a decision in the UK was based on lack of resources which influenced our decision. Or they might argue that we Brits were effete, and unwilling to join battle with cancer. We in turn might recognise the "can-do, must-do" attitude of a US frontier society; if there is a chance of doing something, then it should be attempted.

Sober thoughts on making decisions

But one helpful outcome has been thoughtful words on the pitfalls of consensus meetings and statements in some of the difficult areas of medicine [3, 4]. Just as scientific experts must be wary of imposing their values on the public, the public (or at least their decision makers) need to be more deeply involved in helping to assess the scientific evidence, and especially the balance between good and harm. Perhaps as well we need more recognition that where the effectiveness of any medical intervention is small, the likelihood will be that experts will disagree.

References:
1 Journal of the American Medical Association 1997 277: 519-20.
2 Final mammography recommendation? Journal of the American Medical Association 1997 277: 1181.
3 SW Fletcher. Whither scientific deliberation in health policy recommendations? Alice in Wonderland of breast cancer screening. New England Journal of Medicine 1997 336: 1180-3.
4 SG Pauker, JP Kassirer. Contentious screening decisions. Does the choice matter? New England Journal of Medicine 1997 336: 1243-4.

NEW EB JOURNAL ON THE BLOCK

Evidence-based Health Policy & Management is a sibling publication to Evidence-based Medicine.

The purpose of the new journal is to provide health managers and policy-makers with the best evidence available about the financing, organisation and management of health care. The format is the same as that for Evidence-based Medicine. More than 30 journals are systematically scanned for appropriate articles - reviews or trials - and summarised concisely so that the bones of the results and the quality of evidence can be picked. Most useful are the accompanying commentaries by someone experienced in the field, which help us with the 'spin' and allow us to place the results in the proper context.

Again, as with EBM, there are short articles of classic papers, on skills, or educational or evidence resources to help us use the information better. This new journal is inexpensive (£55 for a years personal subscription), and though the first issue is a bit thin (on pages rather than content, but a journal on evidence based policy and management is never likely to be thick), it will fill out as the editors and their helpers get into their stride.

Evidence-based Health Policy & Management is available from Pearson Professional Ltd, PO Box 77, Harlow, Essex CM19 5BQ, UK. Fax +44 (0) 1279 639609.

MENTAL HEALTH INFORMATION ON THE WEB

Many professionals working in mental health units do not enjoy easy access to library and information services. In order to support evidence-based practice in mental health, the Director of R&D has provided resources for connection to the Internet and the development of OXAMWEB, a collection of mental health information on the Web.

OXAMWEB (website http://strauss.ihs.ox.ac.uk/oxamweb.html) is the THREE-CLICK SITE, designed to provide useful information within "three clicks", and with "EB" benchmarks soon.

Users will thus go straight to the stuff, rather than waste hours chasing round the 'web.

There is both an evidence-based section, and traditional textbook-style information. It is designed for users and their families, as well as professionals.

Do please check it out and send your comments to david.gill@psych.ox.ac.uk

Book reviews

Critical Appraisal

The Pocket Guide to Critical Appraisal
IK Crombie. BMJ Publishing Group 1996, 66pp, ISBN 0-7279-1099-X, price £8.95.

A number of people have asked ***Bandolier***'s advice on evaluating papers. The answer is to get some critical appraisal skills. There are a number of ways of doing this, and the best is probably attending a course of the type arranged by the Critical Appraisal Skills Programme (Claire or Katie on 01865 226968). But if you can't do that, or want an introduction, and want something readable, and particularly if you want something simple to keep on your shelf, then Iain Crombie's book is for you.

It covers all the bases, and tells you what to look out for when appraising clinical trials, cohort studies, case-control studies, and review articles. It has some stuff on statistics - but never heavy and always accessible. A useful addition to the shelves that will break neither the bank nor shelf!

Statistics for the frightened

Clinical Investigations and Statistics in Laboratory Medicine
RG Jones & RB Payne. ACB Venture Publications 1997, 192pp, ISBN 0-902429-21-3, price £21.00.

Most of us feel an overwhelming sense of dread if asked to think about statistics. So if you read a book review which told you that there was a statistics book that might make good reading on the beach, you would probably conclude that the reviewer was either deranged or some kind of anorak!

Richard Jones and Brian Payne have managed to write such a book, though. While the title suggests it is for laboratory medicine types, actually this book is a gentle, hand-holding, informative and innovative entrance to healthcare research for anyone. They give some enchanting one-page backgrounds to famous statisticians, which makes them, and their subject, more human. They lead the new researcher into important areas often ignored by the cognoscenti - like how to put together a grant application, and how to make a really good poster presentation.

But most importantly there is nothing in this book to frighten the horses. In their introduction they tell us that statistics needs more symbols than the Greek and Roman alphabets combined - but *they* use precious few, meaning that those of us who aren't classicists don't feel alienated.

Bandolier was fortunate to have more than one copy. One remains firmly on the shelf for moments of panic (what ***is*** a negative predictive value??), while the other went to a new medical student. But the book will be useful for most people of any background who want to set out to do research themselves, or who want to understand research done by others. It looks like a very useful teaching text.

Correspondence

Some interesting thoughts on data framing from Jon Brassey, TRIP (Turning Research Into Practice), Gwent Health Authority in Pontypool.

IYDT vs NNT

The continual battle to get research into evidence has to be given as much help as possible. To that end I refer to a psychological phenomena known as resonance. According to Tversky and Kahneman [1] humans are motivated to retain a current freedom rather than to obtain a freedom they could have, but don't.

Now what bearing has that on the real world? Gonzales, Aronson and Costanzo [2] carried out a study looking at resonance and the uptake of home insulation. With half of the group they described how much money they could save each year on heating bills. With the other half they gave the same information but framed it in terms of the amount of money lost. The result - those in the latter group had a 50% higher uptake rate.

Parallel this with NNT. In the above example NNT would be the amount of money saved group. Perhaps it would be better if you turn it around and have an 'If You Don't Treat' (IYDT). So if an intervention has an NNT of three, instead of saying "If you treat three people one will benefit" use "If you don't treat three people one will come to harm". Although I haven't come across any application in the health service I feel it may be of some benefit. If the evidence from outside the health service is applicable, one should see IYDT having a greater impact that NNTs.

References:

1 A Tversky, DKahneman. The framing of decisions and the psychology of choice. Science, 1981; 211:453-8.
2 D Gonzales, D Aronson, K Costanyo. Using social cognition and persuasion to promote energy conservation : a quasi experiment. Journal of Applied Social Psychology, 1988; Vol 18 (12, pt2): 1049-66.

Bandolier 2nd Annual

The second ***Bandolier*** volume of collected issues (21 - 34) is available by sending a cheque for £14 made out to **Oxfordshire Health**, to:

Mrs Eileen Neail
Bandolier, Pain Relief
The Churchill, Headington, Oxford OX3 7LJ

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QUESTION TIME

Bandolier is often asked to find or summarise evidence on particular topics. Often we can help, but just as often we cannot. This is usually because we don't have time or resources to dig deeply into subjects where good trials or systematic reviews are not easily found by electronic or other searching.

So as an experiment, this month we run a 'Question Time' Table with some of the unanswered questions of the last few months. ***Bandolier*** asks its readers if they know of any good evidence which may be helpful in any of these topics. If you do, and can supply a reference (or even better a photocopy), then please write to us. We will pass on the information, and perhaps carry some of the evidence in these pages. If it works, then we'll see whether we can run similar exercises in future.

Now ***Bandolier*** does this in the full expectation of being embarrassed by those of you who know the answer, and are surprised that we (and others) do not. So be gentle with us - and remember it is all part of the campaign against squirreling knowledge.

EDITORS

Dr Andrew Moore
Dr Henry McQuay Dr J A Muir Gray

Pain Relief Unit
The Churchill, Oxford OX3 7LJ

Editorial office: 01865 226132
Editorial fax: 01865 226978
Email: andrew.moore@pru.ox.ac.uk
Internet: http://www.jr2.ox.ac.uk/Bandolier

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Question	From	
What is the incidence of infection in insect bites in England? How many insect bites form abscesses? Any comparisons between anti-histamines and antibiotics?	Dina Dhorajiwala	Crouch End
Does meloxicam have any real advantage in patients with risk factors for NSAID-induced ulcers?	David Alston	Brixworth
What is the evidence for use and safety of thioridazine for demented patients in nursing homes?	Avril Danczak	Manchester
Is there any evidence that massage or manipulation improves recovery times in back injury?	Paul Muir	Chesterfield
Do hydrocolloid dressings reduce healing time following surgery?	Paul Muir	Chesterfield
What is the evidence for long-term benefit of vault smears in women treated for carcinoma of the cervix?	Les Ashton	Leicester
Is laser therapy effective in treating wounds and leg ulcers?	Christine Brown	Windsor
What is the evidence for performing routine vaginal examination in women on HRT?	Helen Clayson	Kirkby-in-Furness
Where is the evidence for sterilising bottles and teats for babies up to three months or more?	Anne Edwards	Oxford
What is the evidence of effectiveness on prescriptions for exercise? And what exercise?	Peter Fentem	Nottingham
Prescribing sleeping tablets in hospital is common, especially for the elderly. Is there evidence on whether they should be withdrawn gradually?	RS Gulati	Blackpoool
What is the evidence that women on the oral contraceptive pill should be seen every six months?	Matt Hoghton	Bristol
Do nurse-run clinics in general practice improve outcomes?	Matt Hoghton	Bristol
Is intralesional triamcinalone effective for treating acne scars and keloids?	AJ Munro	Cranford
Where is the evidence that glucosamine is an effective treatment for arthritis?	GS Proctor	Gainsborough
For how long and by how much are risks increased for asthmatics with no history of chicken pox infection who come into contact with an infected person	Stephen Stamp	Princes Risborough